KANSAS MEDICAL JOURNAL.

VOL. VI. TOPEKA, KANSAS, SATURDAY, JUNE 23, 1894. No. 25.

ORIGINAL ARTICLES.

Angina Pectoris.

By C. W. WINSLOW, M.D.

Read before the Northwest Kansas Medical Association, Oakley, Kas., April 2, 1894.

Mr. President and Gentlemen: My subject to-day is one with which I have had but little to do, and I cannot speak from bedside experience; hence, I quote largely from authors with whom I am familiar. Angina from *Angere*, I strangle, I smother; pectoris from *Pectus*, the breast—the meaning is a strangling smothering in the breast, or breast-pang. Ross says it is an idiopathic or symptomatic neurosis characterized by sudden sharp pains in the breast and a sense of impending death. Flint says it appears to be neuropathic and has been termed neuralgia of the heart. Trosseau terms it cardiac epilepsy. Foster, after enumerating several different forms of the affection, viz., reflex, vaso-motor, sympathetic, essential ganglionic, vagus, etc., says some writers recognize two forms, true and false. The former occurs far more frequently in men. True angina pectoris is associated with serious disease of the heart—either valvular disease, degeneration of the muscular tissue, or embolism of the coronary arteries. The false form is induced by tobacco, tea, alcohol, etc., or in a reflex way by indigestion or some uterine disorder.

Angina pectoris was recognized and described first by Rougnon in 1768, and was by Heberden called diaphragmatic gout. At various dates since then this trouble has been recognized and named by different authors in accordance with their notion of the seat of the trouble, whether in the heart, lungs, or diaphragm, all of which have been treated in a voluminous way by their respective observers with more or less obstinacy and discrepancy. The most generally accepted term (says Irving Ross), angina pectoris, is one sanctioned by usage, and merits to be preserved since it presupposes nothing of the nature of a much-discussed affection. The historic cases of John Hunter Arnold, of Rugby, and John Leech are familiar to most medical men.

And Trosseau, in his very interesting article on cardiac epilepsy, was, to my mind, referring to angina pectoris. It was not, however, until toward the end of the eighteenth century that facts noted in connection with the subject were authentically observed and clearly described almost simultaneously in France and England. Since then many vivid descriptions of angina pectoris have been given by various writers, but the study of the complaint leaves several points to elucidate upon which there is more or less discord among authors who have treated the subject.

Dunglison says it is a disease the precise pathology of which is not known. It is an affection of great danger, and is often connected with ossification or other morbid conditions of the heart. Clinically speaking the diagnosis of a typical case of angina pectoris is easy, although the principal symptoms of the disease are subjective. The diseases with which it is liable to be confounded are the cardiac pains of anuerism, the anguish-like pains in cardiac neurosis common to hysteria or the excessive use of tobacco, and the intense and persistent pain of cervicobrachial neuralgia in chronic basilar meningitis. It requires but little diagnostic skill to differentiate between this disease

and the pains of bilious calculi; and in spasmodic asthma there is rarely present the unspeakable sense of sudden death. The constant phenomenon of this disease is sternal pain with a feeling of anguish—of impending death. No pain can be compared with that of angina pectoris. In no disease is there such real physical agony and such keen anxiety. Words are hardly required to make the diagnosis clear to the observer. The pain, paroxysmal in character, comes on in attacks more or less remote, at irregular intervals, and may last from a few minutes to several hours. Its greatest intensity is at the seat of election, the heart, whence it radiates; in severe cases in all directions up, down, and sidewise; to the left side of the neck, to the left shoulder, to the maxillary region, to the intercostal spaces, and down the left arm. In exceptional cases, where the lesion of the cardiac nerves is not limited to the left vertical, it extends to both shoulder blades, to the finger ends, and down the right arm, or even to the lower extremities. Ross says each patient usually has a peculiar term to describe his sensations; they have been compared to a stab in the heart, to a sword-plunge into the left side of the neck and into the sternum; to the thrusting of a redhot iron into the heart; to strangling and suffocation; to the sudden grasp of an icey hand, which gradually tightens until it feels like a clasp of steel crushing the heart. The indefinable anguish that follows the local violence and puts death before the eyes, is stated to be like the anxiety felt by a drowning person. At the outset of the attack the patient instinctively places his hand over the seat of pain; terror is depicted on his palid countenance; he is insensible to surroundings and afraid to move. But the integrity of the intellect is perfect; the patient tries by strong inspiration and deep sighs to increase the capacity of the chest, which feels as if being squeezed in a vise. There is seldom actual difficulty in breathing, and auscultation and percussion reveals nothing. In some cases a spurious respiration, or that peculiar form of dyspnoea, the socalled Cheyne-Stokes respiration, is observed; the patient sometimes experiences the sensation of a foreign body in the air passages. The patient's phonation and deglutition is interfered with; during the attack he speaks but little, and then like one suddenly surprised, full of fear and intent on himself only. The stomach is often sympathetically affected, giving rise to eructions and sometimes vomiting. If the patient does not die from syncope in the middle of the attack as more than half of them do (says Foster), it passes off with a profuse perspiration and escape of flatulent air from the stomach; disappearing as suddenly as it came, leaving the patient exhausted with a desire to sleep after the terrible ordeal through which he has just passed.

Following the attack there may be tremor with slight loss of motion or sensation of the left arm. In some cases visual troubles follow. Recovering from exhaustion, after some days the patient is restored to his previous condition of health. As the disease advances the attacks become more frequent and violent (usually), and more easily brought on, until one of them ends life. Happily for mankind cardiac angina is a rare disease. There are strong evidences on record that a predisposition for angina pectoris may be inherited. People of quiet, sedentary professions and of affluent circumstances are said to furnish the principal contingent for this disease. Tea, alcohol and tobacco are three prominent causes of this disease. Among the occasional causes are sudden anger, joy, walking or riding against a cold wind, hunger, anxiety, and, in fact, anything that acts directly or indirectly on the heart by accelerating its action may cause an attack. A patient with cardiac angina scarcely needs to be reminded of the gravity of his symptoms since he can in a measure foreshadow his fate.

Prognosis is favorable in the socalled false angina pectoris when caused by tobacco and the reflex form provided the cause be removed. Generally speaking where there is an organic complication the danger is greater, and yet typical cases of angina pectoris have been known to survive for twenty years or more. If the trouble be symtomatic

there is but little chance for a cure. During an attack a few whiffs of chloroform or ether may be carefully inhaled, or what is better, a few drops of nitrate of amyl on a handkerchief or blotting paper may be inhaled, and it is recommended by some of our best authors that the patient carry this drug with him constantly. The most convenient way is in glass capsules, 5 to 10 drops. A paroxysm coming on it is only necessary to break one of the capsules on a handkerchief and inhale. Nitroglycerin is valuable in relieving paroxysms, and also as a remedial agent or preventitive. It may be given in the tablet-triturate form 1-100 grain doses or one drop doses of a 1 per cent. spiritous solution. Placing the feet in hot water is a valuable adjunct to the treatment. Dry friction, hypodermic injections of morphine, dry cups between the shoulders, with the administration of stimulants and anodynes, are also useful. After the paroxysm there should be an examination of every organ and every function, and a search made for all the causes of deranged health. Nitroglycerin should be given for several days if the arterial tension is high. General measures applicable to the treatment of chronic conditions and of the cardiac and arterial lesions that are present, may be adopted, and the strictest personal hygiene should be pursued. The actual cautery to the inner side of the left thigh has been highly extolled. Foster, Hare, Rosse, Hammond, Haig, Mays, Ducheme, Eulenberg, Von Hubner, speak very highly of electricity, especially the Faradic current, and Bramwell, in his work on "Diseases of the Heart," is loud in its praise. But the most beautiful and telling evidence in favor of electricity in the treatment of this trouble is in Beard & Rockwell's work on "Medical and Surgical Electricity," p. 645. Rosse remarks: "Electricity has proved so useful in angina pectoris that it is now looked upon as *the only direct remedy*."

THE Eastern Kansas Medical Society meets in Leavenworth Tuesday, July 10.

Hyodermic Injections of Nuclein.

Dr. Victor C. Vaughan, who in common with other investigators has been testing the efficacy of the hypodermic injection of nuclein solutions in pneumonia, tuberculosis, etc., records his results in the *Journal of the American Medical Association*, as follows:

1. The subcutaneous injection of nuclein increases the number of white blood corpuscles.

2. This increase occurs in both healthy and tuberculous persons.

3. With like quantities of nuclein injected, the increase varies with the person. It may be slight, and it may be three-fold.

4. This increase occurs principally in the polynuclear cells.

It is evident as a rule as soon as the third hour after treatment and generally disappears after the forty-eighth hour. If the nuclein shall prove of any value in the treatment of tuberculosis, it will most probably be due to the fact that they increase the polynuclear white corpuscles.

I have been using nuclein in the treatment of tuberculosis in man since May 1, 1893. At first I employed only yeast nuclein, but now I am using spleen nuclien in some cases. When sufficient evidence has been obtained either to reject or recommend the treatment, the results will be communicated to the profession. I may say, however, that only in initial cases may we expect any benefit, and even inregard to these I must have more abundant material and a longer experience before I can speak with any certainty.

THE Kansas City *Medical Index* is now owned and conducted by Dr. H. E. Pearse.

DOCTORS are very poor story writers if we judge by some of the trashy stories that have recently appeared in some of the medical journals. Possibly the journals are hard up for material.

Kansas Medical Journal.

PUBLISHED WEEKLY.

SUBSCRIPTION PRICE, INCLUDING POSTAGE:

Per annum, in advance..... $1 00
Single copies..... 15 cents

Subscription may begin at any time. The safest mode of remittance is by bank check or postal money order drawn to the order of the undersigned. When neither is accessible, remittances may be made at the risk of the publishers, by forwarding in Registered Letter. Address

KANSAS MEDICAL JOURNAL,
723 Kansas Avenue.

W. E. McVEY, B.S., M.D., Managing Editor.

Collaborators:
J. E. MINNEY, A.M., M.D., Topeka, Kas.
S. G. STEWART, M.D., Topeka, Kas.
J. C. McCLINTOCK, A.M., M.D., Topeka, Kas.
M. B. WARD, A.M., M.D., Topeka, Kas.

Topeka, Kansas, Saturday, June 23, 1894.

The Opposition.

The fight against the proposed medical law has begun, and the first gun is fired by a man who from his apparent intelligence one would suppose ought to know better. His principal objection to the proposed law is that it will deprive the spiritualists, the christian scientists and other pretenders of that stripe of the right to practice. His claim that these people have cured hundreds of cases where all the physicians have failed, seems to lack confirmation in his own judgment, for he says when sick he employs a regular physician. His statement that the law is opposed by the leading physicians of the state is not borne out by the facts. The convention which met in Topeka and which unanimously agreed upon the proposed law, was made up of the best physicians of the three schools.

We have yet to learn of a single man in the medical profession, who is a graduate and without cause to fear the effects of the law, that is not in sympathy with the movement. The demand for legislation is not confined to the Regular school. Some of the most enthusiastic workers we have are Homeopaths and Eclectics.

We expect opposition, but it does not come, as has always been claimed, from members of the profession; it comes from those men who though ignorant of the first principles of medicine, imagine their ability to judge of the qualifications for practice are better than those who have spent their lives in scientific investigations.

Disappointments in the Treatment of Tuberculosis.

In regard to the disappointments in the treatment of tuberculosis, the *Medical Age* says:

"We may depend upon it that tuberculosis, like cholera, yellow fever, and smallpox, will owe much of its eventual extermination to preventive measures—to rational hygiene in the individual and to a merciless warfare against contagion-breeding agencies. The sputum of the consumptive must not be expectorated in places where it will dry untouched and prove a focus of evil to the entire environment. The same bed and the same apartment must no longer be occupied by the sound and the sick. Our railway coaches must not be impregnated with disease germs. And in every conceivable way we must seek to guard the healthy from this dreadful inoculation."

This is obvious to all, but we will add that the successful *treatment* of the disease depends also upon the systematic enforcement of these measures after an early diagnosis has been made. Personal hygiene, the removal of all sources of infection or inoculation, are as essential to the well being of the afflicted as the well. That there is any specific cure for tuberculosis our present knowledge does not warrant us in claiming.

However, an early diagnosis, careful attention to the nutrition of the patient, enforcement of hygienic rules and the persistent administration of creosote by the stomach and by inhalation, with those reconstructive agents which are best suited to the individual, will cure many of the cases which may without such management be doomed to an early demise.

Much comfort and considerable addition to the life of the patient may be secured by these same measures even in advanced cases. It is less criminal to give your patient the advice and assistance which your experience teaches may be of benefit, and which, while you cannot promise a cure, you know there are probabilities of such a result, than to blight their hope with a sentence of death with no effort to relieve.

The experience of those men who have studied most carefully this disease proves the possibility of curing a fair per cent. of these cases.

The Significance of Heart Sounds.

A knowledge of the mechanical conditions which produce normal heart sounds leads one to judge pretty accurately of the pathological significance of abnormal sounds.

Could we isolate each element in the production of the first sound of the heart, we would find that each separate sound was governed and modified by the same conditions which give quality, pitch or intensity to other sounds. That part of the first sound of the heart produced by vibrations of the tendinæ cordæ must be regulated in pitch by the length of the vibrating cord and the tension exerted upon it during closure of the valves. The intensity of the sound must depend upon the force with which the blood current is driven against them.

Blood clots or calcarious deposits alter the quality of the sound. The same conditions must also apply to the valvular element of the sound.

Any modification therefore of the first sound must be produced by alterations of the normal conditions of one of these elements. There may be an alteration of the character of the first sound which, though not due to a valvular incompetency, indicates a pathological process. Deposits of fibrin during the early stage of an endocarditis, will change the quality of the valvular sound, though it may not be of sufficient extent to interfere with the closure of the valve or in any way obstruct the current of blood. So an inflammatory process about the tendinæ cordæ may produce such adhesions that instead of having numerous distinct cords we have only one large mass, and as a result this element of the first sound must be greatly altered or altogether destroyed. Any alteration in the muscular power of the heart changes the intensity of the sound. This is most markedly shown in the disappearance of murmurs during prolonged attacks of fever, etc.

Pathological changes in the structure of the heart produce not only alterations of normal sounds, but in addition thereto abnormal sounds characteristic of the lesion. The same mechanical laws must apply as well to these as to the normal sounds. Any change in a valve by deposits, contractions or a shortening of the tendinæ cordæ, sufficient to prevent closure, destroys the normal sound which it should produce, and if the contraction of the muscular walls of the heart is sufficiently strong an abnormal sound is produced by the regurgitant current.

Again, if from inflammatory thickening or adhesions about the edges of the valves, they be prevented from completely opening and the muscular contraction behind be sufficient to produce a current, we may have an abnormal sound, as in certain conditions of the aortic valve, the forcible muscular contraction of the left ventricle forces the current of blood through the contracted orifice with sufficient force to produce a sound.

This same condition of the auriculo-ventricular valves, however, fails to produce a sound for the reason that the passage of blood through these orifices is a passive motion and there is only a slight muscular

contraction of the auricles.

This does not correspond with the usual teaching, but it does correspond to the mechanical laws governing the production of sound, and to our own observation and experience.

A regurgitant murmur may entirely replace the normal sound or if in the mitral, the valvular element of the sound, or if the lesion be not very extensive the normal sound may have added to it or be prolonged by the abnormal sound.

The murmur may be harsh or musical and may vary in all degrees of quality by different conditions of the endocardial tissues. Alterations in the medium through which the sound is conducted to the ear will affect the distinctness of the sound rather than the intensity or quality. A sound may be weak but perfectly distinct, but if the coverings of the heart or of the lungs be thickened by inflammatory exudation, or there is effusions into the pleura or pericardium, the sound may be indistinct or muffled.

A careful study of normal heart sounds in connection with the laws governing the production of sound in general would greatly facilitate a correct interpretation of the pathological significance of abnormal sounds.

Uric Acid in Diathesis.

Dr. John Ford Barbour, of Louisville, in the *American Therapist*, has a very exhaustive article on "The Uric Acid Diathesis and Its Treatment." He describes the uric acid radical as being bibasic and forming two series of salts—the acid urates and the neutral or simple urates. He also describes a quadri-urate, which is held in solution owing to the temperature of the body and the presence of potassium salts. In reference to the origin of uric acid he says:

"In what part of the system is this poison generated? The investigation of Chittenden, of Yale (*Dietetic and Hygienic Gazette*, Febr. 1894), Horbaczewski and others have thrown a flood of light upon this interesting problem. According to these writers, uric acid is a nuclein product and is formed in the following way: All animal cells are made up largely of proteid bodies known as nucleo-albumins, which are phosphorized albuminous bodies. Nuclein is the substance constituting the cell nucleus in all animal cells. It yields a series of decomposition products, called the xanthin bases, which belong to the uric acid group. These bases find their origin in the nucleic acid of the cell nuclei, showing that there is a close relation existing between the chemical changes going on in the cell nuclei and the development of uric acid. This will be made plain by comparing the chemical formulae of two of these bases, xanthin and hypoxanthin, with that of uric acid:

Hypoxanthin	$C_5H_4N_4O$
Xanthin	$C_5H_4N_4O_2$
Uric acid	$C_5H_4N_4O_3$

"Every organ in the body yields uric acid when properly treated, although in different proportions."

He supposes the existence of a relation between digestive leucocytosis and the production of uric acid; the latter being formed by the breaking down of the new leucocytes; that there is increased elimination of uric acid in those diseases attended by breaking down of the tissues, as in the fevers, pneumonia, leukemia, etc. The elimination of uric acid is not affected by the diet, except that the easily digested albumins produce digestive leucocytosis and the formation of uric acid more speedily than do the vegetable albumens. There are only two hypotheses possible in the development of arthrites uratica—either there is increased production or a decreased elimination of uric acid by the kidneys.

"The investigations of Berlioz, Lecanu, Duckworth, Garrod, Haig, Haycraft, Landois, Heidenhain and Ferguson show that the formation (not the elimination) of uric acid is in the relation of one to thirty-three of urea. This makes the average daily normal output of uric acid eleven grains. Where the ratio is different it shows either on the one hand that some of the uric acid

is being retained in the system, or, on the other hand, that it is being eliminated in excess of its formation, and this excess must come from what has been previously stored up in the body.

When the elimination is deficient, if the blood be rendered acid by the drinking of acid wines or beer, the uric acid is deposited in the form of the biurate. If, on the other hand, the blood be rendered alkaline by a vegetable diet, by the use of mineral waters, or by exposure to wet and cold, these deposits are taken up in the circulation again with the effect of producing severe mental depression, violent headache, and all the symptoms of a uric acid storm."

An excess of uric acid in the blood accounts for the occurrence of appoplexy by rupture of miliary aneurisms in the brain, which results from an arterio sclerosis affecting the cerebral arterioles.

In the gouty, nervous disturbances of every sort are common, and from a comparison of the conditions of neurasthenia and those of arthritis, the author concludes that "All neurasthenic patients, without exception, are arthritics." His treatment is limited to the use of piperazin, 15 grains a day, in large draughts of water, outdoor exercise, and a non-nitrogenous diet.

A Protest Against Promiscuous Laparotomies.

Dr. O'Reilly presented the following protest to the St. Louis Board of Health:

"I respectfully call your attention to the many deaths resulting from laparotomy. Surgeons who realize the danger of cutting into the abdominal cavity, the largest and most vitally sensitive of any in the body, stand aghast with horror when they contemplate the fact that the abominations of Jack the Ripper, under the name of modern surgery, are being enacted in their midst every day in cases, too, where neither the conditions of the disease nor the nature of the injuries to the patient justify it, and they feel assured that it requires only your attention to be drawn to this matter forcibly to convince you that some check must be placed on those who, without the most urgent cause, would have recourse to it. The argument of those who sanction the operation is, that antiseptic surgery minimizes the danger from it, but this argument is not borne out by experience, as the deaths from cutting into the abdominal cavity, whether caused by the knife of the assassin or the blade of the surgeon, are almost equally fatal. Nature cannot stand the shock of having the important organs contained in the abdomen tampered with, and it should not be done except under the gravest circumstances. In the name, then, of humanity we ask you to place some safeguards which will protect the unfortunate sufferers from the operation, unless where recommended by two or more physicians."

The protest is a timely one. There is hardly a village in the West which has not its laparotomist. Not that the village surgeon is less competent than his metropolitan brother to do the operation, but extensive experience and a thorough knowledge of the pathological conditions which demand operative procedure can only be obtained after years of observation and constant investigation where such material is abundant. It is readily acknowledged by some of our best abdominal surgeons that had they known in the beginning of their work what they have learned by long experience, appendages might have been saved that were sacrificed through misinterpretation of symptoms, and lives that were lost by operative interference might have been saved by more conservative means.

THE fifth annual announcement of the Kansas Medical College will be issued in a few weeks. There will be only a few changes in the faculty. The new announcement will present on its front page a fine half-tone engraving of the new college building.

Puerperal Fever.

Reports of cases to Cincinnati Obstetrical Society, E. S. McKee, M.D., Secretary.

Two weeks ago Sunday I saw a case of puerperal fever. A primipara, who had been delivered ten days, had a large laceration, which was immediately closed, but four or five days after delivery she developed a high temperature, and when I saw her on Sunday she was at about the end. There had been no local lesion, no peritonitis apparently, but it was one of those cases of general septicemia, with rapid pulse, defective circulation in the extremities, and high temperature. Various means had been resorted to to reduce it without avail. She had been stimulated very freely, but she died within about eighteen hours after I saw her.

Another case I saw with Dr. Kock, corner of Vine and Findlay streets. She had been attended by a midwife, and eight or ten days after delivery he was called because of the conditions existing, and when I saw her she had peritonitis, marked tympanites and tenderness on pressure. Her temperature had been reduced by the use of acetanilide, but elevation redeveloped and she died. The midwife told me she always used solution of carbolic acid freely at times of delivery, and that she had had no similar case.

The case which I have seen this week, the first time on Sunday, was a woman about three months advanced in pregnancy, and without obvious cause had an abortion, with retention of a part of the decidua, and it was allowed to remain until there began to be some offensive odor; then the uterus was curetted, and the physician, who was an experienced and competent man, was very positive he had removed everything.

He had examined the decidua. That woman has now been sick for a week; her temperature has fluctuated very much. Once or twice I have seen her with a record of 90°, and again it has advanced to 105°. In this case there is no local lesion whatever.

The abdomen is slightly tympanitic, but not more than we sometimes see after delivery when the condition is entirely normal. She had no tenderness about the abdomen. Her tongue has been slightly coated, but with a clean moist edge, like the tongue of a convalescent. She vomited once, which was probably because of what she had taken into her stomach. She has had a number of rigors, and this morning had one. Her pulse has fluctuated between 108 and 120; her temperature has gone up and down very remarkably, and yesterday noon it was down to about 100.5°. She had a chill and it rose. It came down again, and she had a rigor during the night, and it went up again to over 103°. She has been treated by stimulation, washing out the vagina, thorough cleansing of the uterus at the time of the removal of all the decidua. She had a suppression of urine to a very marked degree, but yesterday began to secrete freely, and she is now passing a very good quantity of urine.

These cases are entirely separated—widely separated—so that you cannot suppose they were in any way connected in their origin. Two of the cases have proven fatal, and the one I am now seeing we regard as a very serious case.

President: Don't you think the last case was more of a purulent case from retention, or do you consider it peritonitis?

Dr. Taylor: I think they are all cases of sepsis. In this case I should say there has been absorption of the septic matter from the retained decidua.

Dr. J. L. Cleveland also reported a case of puerperal fever.

This case is recent, and I look upon it as what we used to call puerperal fever—puerperal peritonitis. I saw the case in connection with a midwife on the morning of April 5. I was sent for by the midwife to deliver the woman for her. The patient had been in labor for more than twenty-four hours, and was very much exhausted. The head of the child was impacted in the pelvis, and either the uterus had lost its power, or at any rate, there was no apparent effect on the child when she would have a pain. I delivered the child without much difficulty.

The family told me I need not come again unless I was sent for, and I warned the midwife if there was any fever or pain to send for me. I did not hear from her until the second day after delivery, the 7th of April, and then found her in a most dangerous condition. She had a pulse that ranged from 120 to 130, her tongue dry, and she was suffering extreme nervous perturbation.

Her bowels were extremely tender. I did not examine her to see the condition of the uterus, because I did not think it would do any good, and did not care about carrying the infection away. Large doses of quinine had no effect. I got her bowels open with salts — sulphate of magnesia — as soon as I could, and had the nurse wash out the vagina with warm water and boracic acid. I treated the case symptomatically, quieting the pain and perturbation and getting down the fever as well as possible, but the symptoms went on from worse to worse, and she died, as those malignant cases frequently do, within twenty-four or thirty-six hours after I saw her. I cannot imagine the use of the forceps had anything to do in this case. I have not seen a case of puerperal fever before for a long time, and, so far as I can find out from the midwife, she had not seen any. I am always fearful of the midwives, because they are so careless in the way they examine cases and the way they handle them, with regard to carrying about the infection.

Shortly afterwards I had a case to attend in the neighborhood of this midwife, and, in order to save my patient the possibility of calling the midwife in case of emergency, I went to the husband and told him this midwife had a case of puerperal fever and I did not want him to call her in under any circumstances. He promised not to do so. A few days afterward I was called to see this woman at about 3 o'clock A.M., and about 6 o'clock I took a little walk, about fifteen or twenty minutes, and when I returned I found the midwife had been called in and had delivered the child and the after-birth. Of course I was very much chagrined, and watched for results. There were no bad symptoms whatever; she got along as well as I ever saw a woman. Now I do not know whether that was an isolated case or not, or whether it was a specific puerperal fever or not, but I suppose it was.

It is singular the way these cases seem to spring up, and the way they are propagated one from another, while in some cases where there is opportunity to carry infection it is not carried. But we all know very well that during the epidemic of puerperal fever, cases were carried from one to another. I have seen three women, all attended by the same midwife, in the same square, all dead at once. The disease had apparently been carried by this midwife. I do not think there is any doubt about the infection being carried from one to another, but certainly it is not carried sometimes when it seems it should be. It is probable the condition of the woman's health accounts for this to a certain extent.

President: Do you consider that a case of sepsis or not?

Dr. Cleveland: I consider all fevers cases of sepsis.

President: Now the question is whether it is caused by bacteria or sepsis.

Dr. Cleveland: I suppose the bacteria is back of the sepsis.

President: For instance, you would not think a person with erysipelas could produce puerperal fever.

Dr .Cleveland: I have heard that subject discussed a great deal but would hardly know how to discuss it.

Dr. Tailor: In the case I saw, which had been attended by a midwife, I asked her particularly about her custom, and she said she always used a solution of carbolic acid to wash her hands and the patient. Of course, I have no evidence that that was the case.

Dr. Cleveland: Don't you think soap and water is better than carbolic acid, because you cannot use the carbolic acid strong enough? With soap and water you can, at any rate, secure asepsis. I do not think the carbolic acid, when so diluted, would destroy sepsis.

Dr. E. Ricketts: With regard to Dr.

Taylor's cases, I would like to ask him if he thinks the lacerated perineum, which was stitched up, had any connection or bearing upon the case.

Dr. Taylor: It may have had. Of course, if there is a large laceration, there is just that much more absorption surface. If she had had laceration, there could not have been absorption from that place. I did not have anything to do with her until she had been sick for a week. She was well cared for at first; a competent man had charge of her.

Report from Northeast Kansas Medical and Protective Association.

The Northeastern Kansas Medical and Protective Association met at Wetmore Tuesday, June 12, 1894.

More than the usual number of members were present. Drs. Sheldon and Magee were up from Topeka; Holton was represented by Drs. McCandless, Jermaine, and Rafter. There were also Moore, of Effingham; Riggs, of Muscotah; Love, of Whiting; Paddock and Stewart, of Netawaka. Drs. Haigh, Graham and Fitzgerald made up the Wetmore contingent.

Dr. Jermaine called the meeting to order at 2 P.M.

The secretary, Dr. Sink, being absent, Dr. J. A. Rafter, of Holton, was elected secretary *pro tem.*

Dr. Stewart, of Netawaka, set the ball rolling by a remarkably scientific and well-delivered talk on the "Etiology of Pneumonia." The doctor concluded his talk by remarking that his object was to draw out a discussion, and as he had confined himself to the germ theory of the disease in question, the discussion he desired was sure enough drawn out.

Dr. Sheldon, one of the best men in the profession, followed Dr. Stewart with a learned talk on the germicide theory of pneumonia, and also the clinical action of ptomaines in the human economy generally.

Then big, bluff, genial Jos. Haigh, who enjoys nothing so well as an intellectual combat, took the floor and proceeded to have lots of fun at the expense of the "bug" so technically described by Dr. Sheldon.

Dr. McCandless, in his earnest, sincere manner, also gave it as his opinion that fine spun theories were fast taking the place of good common sense, much to the detriment of medical practice.

Dr. Magee, of Topeka, made a pleasant talk along about the same line Dr. Sheldon had followed.

Then Dr. Riggs proceeded to ask some questions which would lead one to believe he had not been fully converted to the "germ theory."

The discussion was protracted, but extremely interesting.

The president, on motion of Dr. Magee, appointed a committee to draft suitable resolutions regarding the death of Dr. Farrar. The committee, Drs. A. B. McCandless, S. M. Riggs and P. R. Moore, made the following report:

Whereas, We have learned with deep regret of the death of a fellow member and former president of our society, M. C. Farrar, M.D., of Atchison, Kas.; therefore be it

Resolved, 1. That we hereby bear testimony to his worth, energy and ability in our profession.

2. We will strive to imitate his excellent example both morally and in elevating the standard of our profession.

3. That these resolutions be placed on the minutes of this society and the secretary be requested to forward a copy to the sorrowing widow and bereaved parents.

The next meeting of this society will be held in Whiting August 14, 1894. An interesting program has been arranged.

JOHN A. RAFTER, M.D.,
Secretary pro tem.

DR. PEPPER has resigned as provost of the University of Pennsylvania, in order that he may devote more time to the practice of his profession.

Bona Fide Facts About Bones.

We have more than two hundred bones in all,
Plenty to break, should we happen to fall;
But should this occur, don't go to a bone-setter,
A qualified doctor will mend you much better.
These bones, says Mr. Huxley the sage,
Vary at different times of age.
But not e'en the humblest seems to lack
Thirty-three Vertebræ down his back.
Now, twenty-four of these said bones
Are really happy in their homes;
But then come five who say, "'Tis humdrum
To keep like this, let's join the Sacrum."
The next four say, "If them's your tricks,
We'll join the club that's named the Coccyx."
Now if this is not one of old Huxley's fibs,
Every one numbers twenty-four Ribs—
Twelve on each side, and all neatly connected,
With Cartilage to Breastbone clearly detected.
In the girdle which binds the shoulders around
Two sizeable bones are very soon found—
Scapula and Clavicle, very grand names,
But to say them too often might turn any brains.
The Pelvis, to which both the legs hold on,
Consists of two bones like the name of a song—
Oh "Ossa innominata" sounds grand, sung—
These divide into three while you're very young:
And if I do not tell you at once
The names of these three, you will say I'm a dunce;
So Pubis, Ischium, and Ilium they are—
They sound quite absurd, but blame their mamma;
For she being young, and only a woman
Said these very queer names were so "sweetly uncommon."
If you suffer from rheumatism in either arm,
Thirty bones there may well give you alarm;
Thirty bones in each leg too has every feller,
By counting the knee-cap, or Patella.
Before passing on in quite easy stages,
These bones bind together by Cartilages;
And where they play freely, one over the other,
A Cartilage coat prevents all bother;
And should you wish to be very particular,
This Cartilage goes by the name of Articular.
These by a delicate membrane lined,
Secrete oily fluid—isn't that kind?
This liquid is always called Synovial;
If that runs short, you won't feel jovial.
As you may have already thought,
The feet are the surfaces of support.
But should the muscles of Calf not contract,
You'd tumble forward, that's a fact.
But this act would bend the leg one way,
So the front of the Thigh muscles come into play.
E'en then, though you try with all your might,
Without help from the Back, you can't stand upright.
To be governed by legs is hard, but depend on,
You'd certainly be worse, if they weren't there to stand on.
Now before I leave this subject, I beg
You will learn the names of the bones in your leg.
The Femur, which lasts from the Thigh to the Knee,
Is a most useful bone, as of course you all see.
And then, too, below the knee we find
A Tibia in front, and Fibula behind.
The Tarsus, and Metatarsus, bones come next—
I can't find a rhyme, so you mustn't be vext.
Then last, and least, comes Phalanges or Digits,
These covered with chilblains will soon give you fidgits.
Before going on, there won't be much harm
In saying the names of the bones in your Arm.
Like the bones in the leg, they are really not numerous,
But from Shoulder to Elbow, you'll find one, called Humerus,
Then come Radius and Ulna, from Elbow to Wrist,
And there are a few others, who lodge in the Fist—
Carpus, Metacarpus, Phalanges, or digits
Are their sweet, pretty names, but these are but midgits.
Then poor little Pollex, the joy of each child,
Of whose virtues and faults, Psalmists don't draw it mild.
Now, although my Lecture is almost done,
We must speak of the Skull, before we go home.
And in adult life our head contains
Twenty-two bones, and sometimes brains.
The number is greater still in youth—
I'm telling you nothing but the truth.
In old age, again, the number's less,
Less trouble to sort, should they get in a mess.
Now the Nasal and Frontal bones come first,
Though should you get injured, these are not the worst.
But should a brick fall on Parietal or Occipital.
Just take a cab to the very best Hospital,
And kind doctors there, if they see you're not shamming,
Will put you to rights with a little trepanning.
The Mandible bone is the last bone of all,
And its none the less useful because it is small.
Now, perhaps, you are glad that the bones are all done,
As this makes a good finish to Lecture One.

—E. M. C., in The Hospital.

Viability of the pyogenic Micrococci.

A somewhat remarkable case of osteomyelitis is reported by Schnitzler (*Centralb. f. Bakt.*), which illustrates the long viability of the pyogenic cocci under certain circumstances. One patient, a man forty two years of age, had suffered octeomyelitis of the right tibia when a boy of seven. There was then discharge of pus and bone from the tibia with resultant sinus formation. The sinus healed in about six months and he remained well during thirty five years. In August, 1892, the right shin began to be painful, and he had occasional fever. After four months of these symptoms he presented himself for treatment at the hospital. Operation showed thickening of the tibia in the sight of the old sinus, but no fistulous opening could be found, and healing of the old process of thirty-years before appeared to have been complete until, chiseling on the bone, an old cavity about the size of a walnut was discoved. The cavity contained a few fragment of bone and a small amount of pus. It was surrounded by a dense layer of bone and was lined with granulation tissues. The contained pus and portions of the granulation tissue removed with the sharp spoon were examined bacteriologically, with the result of obtaining pure cultures of the staph-

ylococcus pyogenes aureus which inoculations into rabbits proved to be virulent.

Because of the dense tissue surrounding the abscess in the bone, and because no fresh source of infection could be discovered, Schnitzler feels compelled to believe that germs pocketed in the bone during the primary infectious process had transmitted their virulence through the many generation which must have existed during the thirty-five years which elapsed between the primary disease and the subacute relapse.

In support of this view reference is made to similar cases reported by Krause, Ressemann, and Mulle, in abscesses of bone developed in the site of suppurative processes which had "healed" thirty, thirty, and four years before respectively.

New Remedies.

Pharmaceutiische Post.

Hydrargyrum potassium hyposulphite, $_3Hg\ (S\ O_3)_2 + 5K_2S_4O_3$. Colorless crystals, readily soluble in water, which do not cause a precipitate in solutions of albumen. The drug contains 31.4 of mercury. According to Dreser and Camerer injection of this preparation are attended with no more pain than the ordinary morphine injections, cause no local irritative or escharotic effects, and insure the possibility of accurate dosage. One gramme of mercuric chloride is equal to 2.32 grammes of this preparation, and may, therefore, be ordered as follows:

℞ Hydrarg. potass. hyposulphit... 0.25
Solve in aquæ dest.....10.0

M. S.—Inject one-half syringeful (this amount contains 0.005 of the remedy, or equal to 0.01 grammes sublimate).

AN American physician, writing from London, says: "The absorbing topic for discussion among English surgeons is now, *not* Shall healthy ovaries be removed for neurotic troubles? *but* Shall ovaries be removed at all?"

No Law in Ohio.

The Ohio legislature has adjourned without passing the bill presented by the physicians of that State. It is a discouraging end to all their labor. We sympathize with them but we have become hardened to such disappointments. They don't count any more. We simply wait for the next legislature and begin over again. Perhaps this term if not this perhaps next, but some time at any rate we will succeed.

DR. BURGESS, of Tennessee, claims to have cured a melanotic cancer by the administration of calcium sulphide in ⅙ grain doses three times a day. Treatment was continued five weeks.

CEREBRO-SPINAL SYPHILIS.—Strozewski has recorded three cases of syphilitic affection of the brain and spinal cord, two of which recovered, the other being fatal. A post mortem examination showed tumefaction and adhesions of the membranes of the brain and syphilitic degeneration of the blood vessels.—[*Gazeta Leskarski*, No. 33, 1893.

PROF. VAUGHN HARVEY says that smoking diminishes muscular power and hastens the onset of fatigue. He says: "The smoking habit is so utterly obnoxious to the spirit of an advanced civilization that it is a marvel that the vice should be tolerated in decent society, and it is to be hoped that the time is not far distant when tobacco smoking and liquor drinking—even in so-called moderation—will be regarded in the same light as opium smoking, the cocaine habit, and other drug vices." The professor certainly does not derive such a hope from the present prevalence of the vice.